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No. 07-1434

Supreme Court, U.S.
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Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Petitioners,

v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

SUPPLEMENTAL BRIEF OF THE PETITIONERS

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CORPORATE DISCLOSURE STATEMENT

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INTRODUCTION

Pursuant to Rule 15.8, Petitioners respectfully submit this Supplemental Brief to bring to the Court's attention a regulatory compliance bulletin issued by the South Carolina Department of Insurance (DOI) on August 28, 2008. Bulletin No. 2008-15 is an official regulatory interpretation of newly enacted S.C. Code § 38-71-242. It explains that § 38-71-242 requires insurers to pay ***all*** claims not paid as of June 4, 2008 based on the DOI's longstanding interpretation of the term "actual charges," as that term is used in specified disease insurance policies that do not define the term.

The Bulletin provides additional support for Petitioners' argument that the Fourth Circuit's decision upsets well-established principles of state law. Under those principles, courts (including the federal judiciary) must defer to state agency interpretations. The Fourth Circuit's decision, if left standing, will undermine deep-seated principles of federalism and comity by ignoring the role of state insurance regulators and imposing harmful consequences on the insurance industry and the citizens of South Carolina. The DOI's rapidly issued Bulletin leaves no doubt about the agency's position regarding the interpretation of the term "actual charges"—a position that the Fourth Circuit erred in refusing to consider even prior to § 38-71-242. This is precisely why the Court should issue an order granting the petition, vacating the Fourth Circuit's decision, and remanding the case to the Fourth Circuit so that it has an opportunity to reconsider its decision in light of the State's new law, and the DOI's interpretation of that law.

THE REGULATORY BULLETIN

Following the Fourth Circuit's decision in this case, South Carolina enacted § 38-71-242, which statutorily defines the term "actual charges." That pivotal definition applies to all specified disease insurance policies (unless the term is defined therein), and provides that "actual charges" means the lowest amount "that the health care provider ... (a) agreed to accept ... as payment in full for the goods or services provided to the insured; [or] (b) agreed or is obligated by operation of law to accept as payment [for government administered health care programs]." S.C. Code § 38-71-242 (2008).[1]

As the agency charged with regulating the insurance industry and enforcing the insurance laws within South Carolina, the DOI has very recently issued a regulatory bulletin. Specifically, Bulletin No. 2008-15 provides official regulatory instructions concerning § 38-71-242. Such regulatory bulletins are the "method by which the Director of Insurance formally communicates with persons and entities regulated by the Department." Bulletin No. 2008-15, at 3 n.1 (reprinted in the Appendix ("App.") at 5a n.1). Regulatory bulletins provide insurance companies, consumers and courts with guidance and instruction on how the agency will interpret and enforce statutes the legislature has entrusted the DOI to administer. *Id.*; *see also* S.C. Code § 38-3-110(2) (2007) (mandating that the DOI ensure "that

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[1] S.C. Code § 38-17-242 (2008) is available at: http://www.scstatehouse.net/sess117_2007-2008/bills/1104.htm (last visited Sept. 9, 2008).

all laws of this State governing insurers or relating to the business of insurance are faithfully executed and make regulations to carry out this title and all other insurance laws of this State, the enforcement or administration of which is not otherwise specifically provided for").

Bulletin No. 2008-15 explains that § 38-71-242 "codifies the Department's longstanding interpretation of the term 'actual charges' ... in supplemental cancer policies." App. 3a. According to the Bulletin, the DOI's consistent interpretation of "actual charges" requires insurance companies "to pay benefits on an expense-incurred basis," *id.*; it does not require, as the Fourth Circuit would, insurers to pay benefits "in amounts greater than a medical provider agreed to accept as payment in full for services rendered to the insured." *Id.* at 3a-4a.

The newly-promulgated regulatory bulletin further provides that the newly-codified definition of "actual charges" is not only consistent with the DOI's longstanding interpretation of the term, but also is supported by fundamental "public policy considerations" and "basic principle[s] of insurance." *Id.* at 4a. Insurers are in the business of indemnity. That means that insureds are entitled to recover benefits only for actual out-of-pocket expenses. As the DOI recognized, its interpretation of "actual charges," now codified, implements this principle, "ensur[ing] that a few insureds and beneficiaries do not receive windfalls in the form of payments of benefits greater than sums actually paid to health care providers." *Id.* Indeed, the DOI's interpretation not only prevents windfall payments to some insureds, but it also helps to keep insurance

premiums affordable and insurance companies solvent. *Id.*

Bulletin No. 2008-15 applies § 38-71-242 to all claims not yet paid, unless a final judgment issued prior to June 4, 2008 expressly requires otherwise. Specifically, Bulletin No. 2008-15 provides that, in order to comply with § 38-71-242, "insurers that have issued supplemental cancer policies or other specified disease policy in this state containing the term(s) 'actual charge,' 'actual charges,' 'actual fee,' or 'actual fees' and that do not contain an express definition of those terms ***may not pay any claim or any benefit in excess of the amount specified in S.C. Code Ann. § 38-71-242,***" "[u]nless expressly required to do so by a final judgment issued before June 4, 2008 by a court of competent jurisdiction." *Id.* at 5a (emphasis added).

ARGUMENT

I. Bulletin No. 2008-15 Underscores The Importance Of Ensuring That Federal Courts Defer To States' Departments of Insurance.

The South Carolina legislature and the DOI have now spoken authoritatively on the issue presented in the Petition for Certiorari. As explained in Petitioners' Reply to Ward's Opposition to the Petition for Certiorari, newly enacted S.C. Code § 38-71-242 reinforces, reiterates, and codifies the DOI's longstanding interpretation of "actual charges" as the amount an insured is legally obligated to pay for services. Indeed, the South Carolina legislature enacted § 38-71-242 soon after the Fourth Circuit's decision in this case, unequivocally repudiating the

Fourth Circuit's refusal to defer to the DOI's longstanding interpretation of "actual charges."

Now, the DOI has issued Bulletin No. 2008-15 in order to provide insurance companies and their insureds immediate and authoritative guidance as to how the term "actual charges" has been, and will be, interpreted in supplemental cancer policies and the claims to which this definition applies under § 38-71-242. The Bulletin confirms that § 38-71-242 is a repudiation of the Fourth Circuit's refusal to defer to the DOI's prior interpretation of state law.

The Bulletin also underscores the error of the Fourth Circuit's approach to this case. Congress has expressly left the regulation of insurance to the authority of the States, and the South Carolina legislature has expressly granted the DOI regulatory and interpretive authority over insurance contracts. Yet the Fourth Circuit's refusal to defer to the DOI would take that authority away. Bulletin 2008-15, together with § 38-71-242, attempts to reclaim the DOI's regulatory and interpretive authority over insurance contracts.

The Bulletin makes plain that by ignoring the DOI's regulatory expertise, the Fourth Circuit endorsed an interpretation of the term "actual charges" that is based on a fundamental misunderstanding of the role of insurance contracts. As the Bulletin states, "the basic principle of insurance" is "that insurance is a contract of indemnification": "an insured must suffer an actual out-of-pocket loss to receive payment of benefits." *Id.* at 4a. The Fourth Circuit's interpretation of "actual charges," however, would have provided windfalls to some insureds "in the form of payments of benefits greater than sums actually paid to health

care providers." *Id.* These "windfalls inevitably would cause premiums to increase exponentially for all and would restrict the availability and affordability of supplemental disease policies, to the detriment of the citizens of this state." *Id.*

In § 38-71-242 and Bulletin No. 2008-15, therefore, the legislature and the DOI have now spoken. The Fourth Circuit's decision is plainly an intrusion on the regulatory expertise and authority of the DOI, and the Fourth Circuit should be instructed to reconsider its decision in light of these intervening developments.

II. Bulletin No. 2008-15 Underscores The Need For This Court To Grant The Petition, Vacate The Fourth Circuit's Decision, And Remand This Action In Light Of Section 38-71-242.

Bulletin No. 2008-15 makes clear that under § 38-71-242 Petitioners and other insurance companies ***are prohibited*** from paying claims or benefits under specified disease insurance policies in an amount that exceeds the statute's definition of "actual charges," from the date of the law's enactment, unless a court has issued a final judgment as of June 4, 2008. In other words, the Bulletin affirms that § 38-71-242 governs claims that have not yet been paid ***unless*** a final judgment has been entered to the contrary.

Thus, as the Bulletin makes clear, and as Petitioners articulated in the Reply Brief, the definition of "actual charges" embodied in § 38-71-242 must be applied in this case: the claims of the Respondent and the class members have not yet been paid and no final judgment has been entered

here. Nevertheless, in spite of the legislature's clear statutory mandate, subsequent to the filing of Petitioners' Reply Brief—but prior to the issuance of Bulletin—the District Court denied Petitioners' motion for judgment on the pleadings, which argued that § 38-71-242 must be applied to this case. Order On Motion For Judgment On The Pleadings And To Dismiss, *Ward v. Dixie Nat'l Life Ins. Co.*, No. 3:03-3239-JFA, slip op. (D.S.C. Aug. 12, 2008). The District Court rejected Petitioner's argument, concluding that it was bound by the Fourth Circuit's prior decision requiring that the term "actual charges" be construed in favor of the insured. *Id.* at *7.

The District Court's decision only compounds the Fourth Circuit's error in refusing to defer to the DOI's longstanding interpretation of the term "actual charges." A GVR in light of the statute codifying the DOI's interpretation—and in light of Bulletin No. 2008-15—is therefore warranted. Both are "intervening developments" by authoritative arms of state government that the Fourth Circuit "did not fully consider." *Lawrence v. Chater*, 516 U.S. 163, 167 (1996). Moreover, these new sources of law "reveal a reasonable probability that the decision below rests upon a premise"—namely an erroneous view of the state agency's prerogative—"that the lower court would reject if given the opportunity for further consideration." *Id.* A GVR would instructively remind the Fourth Circuit—and the entire federal judiciary—that principles of federalism matter deeply, particularly in the arena of insurance law. In that heavily regulated arena, especially in light of Congress's express deferral of regulatory authority (under its Commerce Clause

power) to the laws of the several States, the State's laws and interpretations of those laws must be respected.

CONCLUSION

For all the reasons stated in the Petition, Reply and this Supplemental Brief, this Court should grant the petition, vacate the Fourth Circuit's decision, and remand the case in light of S.C. Code § 38-71-242 and Bulletin No. 2008-15. Alternatively, the Court should grant the petition and consider the Fourth Circuit's decision on the merits.

Respectfully submitted,

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APPENDIX

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Mark Sanford
Governor

Scott H. Richardson
Director of Insurance

Bulletin Number 2008-15

TO: All Life, Accident and Health Insurers Writing Supplemental Cancer and Other Specified Disease Policies

FROM: Scott H. Richardson, CPCU
/s/ Scott Richardson

SUBJECT: Compliance with S.C. Code Ann. § 38-71-242

DATE: August 28, 2008

I. Background

Section 38-71-242 of the South Carolina Code became effective on June 4, 2008. That section provides:

> (A)(1) When used in any individual or group specified disease insurance policy in connection with the benefits payable

for goods or services provided by any health care provider or other designated person or entity, the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees' shall mean the amount that the health care provider or other designated person or entity:

(a) agreed to accept, pursuant to a network or other agreement with a health insurer, third-party administrator, or other third-party payor, as payment in full for the goods or services provided to the insured;

(b) agreed or is obligated by operation of law to accept as payment in full for the goods or services provided to the insured pursuant to a provider, participation agreement, or supplier agreement under Medicare, Medicaid, or any other government administered health care program, where the insured is covered or reimbursed by such program; or

(c) if both subitems (a) and (b) of this subsection apply, the lowest amount determined under these two subitems; and

(2) must include any applicable deductibles, coinsurance requirements, or co-pay requirements applicable to the insured under any government administered health care program or

any private primary health insurance coverage for the health care provider's goods or services provided to the insured.

(B) This section applies to any individual or group specified disease insurance policy issued to any resident of this State that contains the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees' and does not contain an express definition for the terms 'actual charge', 'actual charges', 'actual fee', or 'actual fees'.

(C) Notwithstanding any other provision of law, after the effective date of this section, an insurer or issuer of any individual or group specified disease insurance policy shall not pay any claim or benefits based upon an actual charge, actual charges, actual fee, or actual fees under the applicable policy in an amount in excess of the 'actual charge', 'actual charges', 'actual fee', or 'actual fees' as defined in this section."

This statute codifies the Department's longstanding interpretation of the term "actual charges" or similar wording in supplemental cancer policies. For many years, spanning the terms of three directors of insurance, the Department has consistently interpreted those terms to require insurers to pay benefits on an expense-incurred basis, and not to pay benefits to insureds in amounts greater than a

medical provider agreed to accept as payment in full for services rendered to the insured.

Section 38-71-242 is based upon the same legal and public policy considerations upon which the Department has continuously relied in interpreting the term "actual charges" in supplemental disease policies. The statute embodies the basic principle of insurance, codified at S.C. Code Ann. § 38-1-20(19), that insurance is a contract of indemnification, and that an insured must suffer an actual out-of-pocket loss to receive payment of benefits. This construction of the term "actual charges" ensures that a few insureds and beneficiaries do not receive windfalls in the form of payments of benefits greater than sums actually paid to health care providers, either by insureds or beneficiaries, or by a primary health insurer. Such windfalls inevitably would cause premiums to increase exponentially for all and would restrict the availability and affordability of supplemental disease policies, to the detriment of the citizens of this state. Finally, the statue comports with the Department's consistent position that allowing payment of benefits in excess of amounts actually paid to health care providers creates opportunities for fraudulent conduct, such as deliberately inflating medical bills solely for the purpose of allowing an insured or beneficiary to collect greater benefits under a supplementary disease policy.

II. Compliance with S.C. Code Ann. § 38-71-242

Unless expressly required to do so by a final judgment issued before June 4, 2008 by a court of

competent jurisdiction, insures that have issued supplemental cancer policies or other specified disease policy in this state containing the term(s) "actual charge," "actual charges," "actual fee," or "actual fees" and that do not contain an express definition of those terms may not pay any claim or any benefit in excess of the amount specified in S.C. Code Ann. § 38-71-242.

Every insurer licensed in this state that has issued a supplemental cancer policy or other specified disease policy subject to the provisions of S.C. Code Ann. § 38-71-242 shall transmit a notice, in a form approved by the Department, to the named insured or beneficiary of each such policy informing him or her of the content of S.C. Code Ann. § 38-71-242.

III. Questions

Questions should be directed to the attention of Carla Griffin @ cgriffin@doi.sc.gov or (803) 737-6230.[1]

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[1] Bulletins are the method by which the Director of Insurance formally communicates with persons and entities regulated by the Department. Bulletins are departmental interpretations of South Carolina insurance laws and regulations and provide guidance on the Department's enforcement approach. Bulletins do not provide legal advice. Readers should consult applicable statutes and regulations or contact an attorney for legal advice or for additional information on the impact of that legislation on their specific situation.